

Hospital Letterhead

Hospital ABN 3.

Date of Notice

Name of Patient

Admission Date

Address

Health Insurance Claim (HIC) Number

City, State, Zip Code

Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: *(Insert the name of the addressee.)*

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)*. Your attending physician has been advised and has concurred that beginning *(specify date of first noncovered acute care day)* further *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be furnished safely in another setting)*. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on *(specify date)*.^{1/} If you leave the hospital on *(specify date)*, you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

However, this notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion:**

Request **immediately**, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- **If you do not request an immediate review:**

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- **QIO Review Results:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on *(specify date)*.^{1/}

- **QIO Address:**

(QIO Name)

(Address)

(Telephone Number)

Sincerely,

*(Title, e.g., Chairperson of Utilization Review Committee,
Medical Staff, etc.)*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from

_____ *Name of Hospital*
at _____ *Time* on _____ *Date*. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

Signature of patient or authorized representative

Time

Date

cc: QIO

Attending Physician

October 2003 - Form CMS-10092-C.

^{1/} _____ Insert: the date following the day of receipt of the hospital notice.